Bulletin

OF THE NATIONAL TUBERCULOSIS ASSOCIATION

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JUNE, 1950

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Complete Follow-Up Is Essential Part of Case-Finding

Health Councils—Meeting Ground for All Health Forces

Assn. Board Includes Survey of Meetings in Self-Evaluation

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After the X-Ray—What?

Across the EDITOR'S DESK

A Whole Program

When we were in school we were taught that a whole is equal to the sum of all its parts. Complete case finding in tuberculosis control means that we must consider all its phases and not X-raying alone. We cannot honestly say that we have found a case of tuberculosis until the individual concerned has been followed up to the point of complete and thorough diagnosis.

When the X-ray came of age, so to speak, too many of us jumped on the bandwagon and started intensive mass X-raying without giving proper or sufficient thought to other parts of the case-finding program, especially the follow-up. Without a sound and effective follow-up plan, our case-finding program is not a whole program.

Health departments, tuberculosis associations, and others concerned are X-raying more than ten million persons each year. This comes under the head of case finding. Statistically we are finding that between three and five per cent of this total is comprised of individuals who must be X-rayed again to determine whether or not tuberculosis is present. We are not doing this and the first step in our follow-up program is falling down. When the first step is weak, the second, third, and fourth steps will become still weaker.

Why is the follow-up part of our case-finding program weak? Is it not time to re-evaluate and find out? Mass X-ray surveys enlist the cooperation of the entire community. We use many methods to get people to come to the X-ray machines. Except for the actual taking of the X-ray and the reading of the films, not too much technical knowledge is necessary. We use an army of volunteers, we get cooperation from the newspapers and the radio, pamphlets are distributed, posters put up for everyone to see, special programs are put on in the schools, speakers, are sent out into the community, and the cry is "Get your chest X-ray today!" This is the easy part, the glamorous part; the tedious technical part comes next.

Now we need the highly-trained technicians, the experts who can follow through and make the other parts of our case-finding program as effective as the first part. We need a sound and workable plan which will enable us to get those persons whose small screening films were not negative for tuberculosis back for a 14"x17" film. Well-trained public health nurses, and a cooperative, interested medical society are a must if we are to succeed. Suspicious cases must be re-X-rayed.

The next step is still more important and still more difficult. Here the nurse and the physician must work as a team. This is not a job the layman can do or should do. Diagnosis of tuberculosis is a technical job that only the trained physician is capable of doing. The responsibility of encouraging those suspected of having tuberculosis to take full advantage of the opportunities for diagnosis rests with the public health nurse working under the supervision of the physician. We believe this is not being done as much as it should be.

We must know the facilities of our community, we must know how great a load those facilities are geared to handle completely, and we must plan our X-ray program so that those facilities will not be over-taxed or over-burdened to the point of no return. A whole is the sum of all its parts. We cannot and must not plan a whole case-finding program unless we are sure that all the parts of the program are going to be complete. X-ray, follow-up, diagnosis, hospitalization—these four all together equal good, effective tuberculosis case finding.—*Frank T. Jones, Associate, Industrial and Mass Radiography, NTA.*

B U L L E T I N

OF THE

NATIONAL TUBERCULOSIS ASSOCIATION

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ELLEN LOVELL, *Editor*
ELIZABETH HODGSON, *Associate Editor*

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Follow-Up—A 'Must' in Case-Finding

Pre-Survey Planning Should Go Far Beyond the Mass X-Ray Procedure Itself and Include Arrangements for Final Diagnosis and Care of Discovered Cases

By DAVID ZACKS, M.D.

A COMMUNITY-WIDE chest X-ray survey may be compared to a huge, loose dragnet. The diffident and disinterested avoid it. Extroverts walk into it boldly; introverts, perhaps, fearfully. The majority of those examined go through easily. A relatively small number, however, are held. They are the ones whose X-rays show signs suspicious of tuberculosis, tumors, heart disease, or other chest conditions.

All is well for those who are tagged "normal." Those comprising the second group, whether because of unsatisfactory small films, or shadows due to extraneous objects or indicative of some sort of chest disease, will not receive a report until notified of the necessity for a 14"x17" film.

Unless this is done promptly and the "suspects" properly informed and re-examined and final diagnoses arrived at, all of the effort put into the community X-ray survey may be called into question.

Small Film Interpretation

In some chest X-ray surveys, reports are limited to results of the small film interpretation. Subsequent study, when necessary, is then left to the judgment of the person concerned and his physician. What if the "suspect" does not visit his physician? What if the doctor does not take the X-ray report seriously in the absence of clinical signs and symptoms?

Reporting of the X-ray findings based on small film interpretation is reprehensible for the following reasons:

1. Small screening films are less reliable than specific disease tests such as those for diabetes and syphilis.

2. Technically poor films and overreading of small films are inevitable.

3. Public health will not be served by ignoring possible communicable disease.

4. Diagnosis of silent chest conditions is not easy. The general practitioner, in his subsequent study, needs the aid of 14"x17" film interpretation made by competent chest physicians or roentgenologists.

Follow-Up Essential

Follow-up of "suspects" resulting from chest X-ray examination is difficult, time-consuming, and entails some expense. But, it is an activity which is essential in tuberculosis case finding. Careful consideration must be given to a follow-up plan in the pre-survey organization. Arrangements must be made for active participation in this program by the local chest clinic, the local hospital, or the out-patient department of the tuberculosis sanatorium.

Follow-up in mass chest X-ray surveys usually consists of (a) arranging for retake appointments for 14"x17" films to complete the screening procedure in order to render a reasonably accurate X-ray film report to the family physician and (b) bringing together the "suspect" and his physician or organized diagnostic facility to confirm the findings noted on the small and large screening films.

The follow-up of tuberculosis suspects, I believe, is the responsibility of the official health agency. The official health agencies, however, may need some financial assistance for this undertaking.

The voluntary health agency and civic groups who sponsor community chest X-ray surveys should develop a plan with local physicians for the follow-up of non-tuberculosis suspects—those who may have tumors, heart disease, or other chest conditions. These agencies, of course, can contribute to the effectiveness of the follow-up by thorough community organization and concise information in addition to necessary publicity. Before undertaking a community-wide campaign, the sponsors should ask themselves the following questions:

1. Do we have adequate funds and experienced personnel to initiate and complete a community-wide campaign?

2. Is there adequate local civic group sponsorship in addition to the organized health department and the voluntary tuberculosis and health association for complete, well-timed, community organization?

3. Will the local physicians participate in the chest X-ray survey plan? Is the local chest clinic or hospital willing and able to help the physician with diagnostic problems for those who cannot afford private consultation?

4. Is the local health agency ready with money and personnel to undertake the follow-up of tuberculosis suspects?

5. Do the local lay groups understand fully the problem of organization? Do the leaders have the time

THE AUTHOR

Dr. Zacks is chief of clinics, Tuberculosis Division, Massachusetts Department of Public Health. A former president of the Massachusetts Trudeau Society, he is the author of many articles on tuberculosis in the teens and of *Photoradiography in Search of Tuberculosis*, published in 1949. His article is a contribution from the Committee on Medical Information and Public Relations of the American Trudeau Society

as well as the willingness to assume such an exacting responsibility?

6. Will there be sufficient reliable canvassers? Is there a workable alternative method to bring people to the X-ray units if the canvassing plan breaks down at the last minute?

7. Will the publicity for the campaign be generous? There is need for more and better publicity repeated often enough to obtain majority participation.

8. Will the promotional material be sufficiently concise, readable, and repeated often enough to enlist interest and public participation effectively?

9. How will the survey procedure be made clear to the public? For example, will the public be told that there will be one small film for most of those examined, a necessary second film, 14″x17″ for some, and that reports to physicians will follow the reading of the second film?

10. How can the individual be reassured during the period of waiting for the repeat film or when he may find himself perplexed by a letter which tells him to consult his physician?

Role of Nurse

The key to good tuberculosis follow-up is an efficient and cooperative public health nurse. Her interest and participation should be enlisted early in the pre-survey planning. She will then understand her place in the working of the chest X-ray program and her importance in the follow-up of the suspected cases after the survey is completed. Indeed, the chest X-ray survey is not completed until the follow up of suspects is completed.

During the survey period, when more than one mobile X-ray unit is used, the public health nurse or social service worker will need to give full time to the re-take schedules. If she needs help this should be provided, if she needs transportation a car should be assigned. After the preliminary survey has been completed her task with the follow-up of suspects will be heavy for many months. A suggested outline for her activities follows:

A list of persons to be recalled for the 14″x17″ films is mailed to the designated public health nurse in the community each week during the course of the survey. This public health nurse sends re-take appointment cards to each person listed.

If the person fails to report for the re-take film on the first appointment, a second appointment is made and another card is mailed to the individual. If there is no response to the second appointment invitation, further follow-up is indicated by telephone or a home visit by the public health nurse to secure cooperation. These cases are a challenge to the tact and persuasiveness of the public health nurse and her success is measured by her interest and enthusiasm for the program.

Procedure

A copy of the doctor's X-ray report is sent to the public health nurse responsible for the follow-up program.

1. The questionnaire section of the report is to be filled in by the physician concerned. The completed form is to be returned to the chest X-ray survey office.

2. After an interval of two weeks, the public health nurse contacts the doctor to discover if the person named in the report has visited his physician as he was encouraged to do.

3. When she finds that the person *has* visited his physician, the public health nurse inquires whether or not the physician has completed the questionnaire and forwarded it to the chest X-ray survey office.

4. When she finds the person has *not* visited his physician, the public health nurse secures the doctor's permission to visit the person at his home to explain the necessity for cooperation with his doctor and arrange, if necessary, for such a visit. With the doctor's consent, the public health nurse may arrange for the necessary follow-up examination to be made at either a local chest clinic, designated hospital, sanatorium outpatient department, or other chest clinic. When this arrangement is followed, or when there is no private physician named in the special case, the public health nurse completes the questionnaire part of the report and returns it to the X-ray survey office.

5. When the person X-rayed is a non-resident of the community, the public health nurse forwards the doctor's report to the proper health agency with a letter explaining the reason for the report and suggesting disposition.

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NEW NAMES ANNOUNCED BY MAINE ASSOCIATIONS

A change in name from the Maine Public Health Association to the Maine Tuberculosis Association was announced recently in the organization's newsletter, *Maine Events*.

The need for greater concentration on tuberculosis control, the development of other voluntary agencies to carry out programs against other health problems, and the fact that the identity and functions of the association were confused with those of the official health services were given as principal reasons for the change.

At the same time, announcement was made that the Cumberland County Public Health Association and the Bangor Anti-Tuberculosis Association had changed their names to the Cumberland Tuberculosis and Health Association and the Bangor-Brewer Tuberculosis and Health Association, respectively.

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EVALUATION COMMITTEE

Complete evaluation of the Summit County (Ohio) Tuberculosis and Health Association and of its program will be undertaken by a committee recently set up for that purpose, according to the association. The committee is headed by the Reverend Harry Nicholson.

Local Health Councils Aid TB Control

Provide Meeting Ground for All Forces, Both Official and Voluntary, Working for Better Community Health—Help Solve Problems by Coordinating Resources and Activities

By ELLEN BOYCE

PERHAPS you will remember "Pelle's New Suit," the charming story of a little boy who lived in Sweden. He had a lamb that he took care of all by himself. The lamb grew bigger and bigger, and his beautiful white wool grew longer and longer. Pelle grew bigger, too, but unlike the lamb his coat got shorter and shorter.

Pelle decided he would have to have a new suit. You can probably guess what he did as the first step in getting it. He cut the lamb's wool. But that was only the beginning. A great many people had to help Pelle get his new suit—someone had to card the wool, another had to weave it into cloth, and still another had to fashion the suit. The little boy himself had to work the hardest of all. The craftsmen in the community were willing to cooperate in Pelle's project, but in turn they expected to be repaid, and since Pelle had no money they accepted his service as pay.

Need for Clearing House

We in the voluntary field of tuberculosis control have much in common with Pelle. We realize there is a job to be done. Many people are needed to do that job, but sometimes it is difficult for us to decide just how and where we should go to get it done. Then, too, the picture is constantly changing. In the early days the voluntary agency was in many instances the only agency working in a community to establish better health facilities. As progress was made, more people became aware of the needs. Even though official agencies were established, the community continued to organize voluntary agencies to meet special health problems.

As the scope of the official agencies' program broadened, and as the number of voluntary agencies in the health field continued to increase, it was only natural that the need for a clearing house or coordinating facility became more apparent. The health council is just such an agency. It is nothing more or less than a meeting ground for all forces, professional and lay, working in the community for the establishment of good public health.

Health Council Purpose

Whether we are in a rural or an urban community, a health council can be of benefit to our agency. Through association with the membership of the council we come to know the agencies in our community. By planning and working together we can avoid overlapping and duplicating each other's activities; we can study mutual problems and we can plan health programs which are related to these problems. Our chances of stimulating public interest will be greater and through community action we will be able to meet the needs.

A more detailed list of ways in which a health council may function in any community has been set down in *Stepping Stones to a Health Council* published by the National Health Council. They are as follows:

1. By developing an understanding, in so far as possible, of the planning and thinking of all organizations and groups concerned with public health.

2. By working to prevent overlapping and duplications.

3. By studying the over-all health needs of the community through inventories, surveys or other fact-finding devices.

4. By helping to develop a community health program to meet needs discovered by the fact-finding activities.

5. By stimulating, through sound educational programs, public interest in health problems and their solution.

6. By expressing itself forcefully on health legislation affecting the community.

7. By rendering to its members services that are needed in common by them.

Role of TB Assn.

In our own guide, *Building a Community Program for Tuberculosis Control*, we find this statement, "There is no room for competition in tuberculosis control, but there is ample room for coordinated activities."

This crystallizes our basic philosophy and if we honestly believe that no agency or group of agencies can work alone to control tuberculosis, it is apparent that the tuberculosis association would want to affiliate with the health council. If there is no health council, it may fall upon the tuberculosis association to instigate the formation of one by bringing together all resources, both official and voluntary, thereby mobilizing the community not only for tuberculosis but for health in its broadest sense.

To affiliate with the council or even to organize one is not enough. We must believe in its function, its democratic process, and be willing

THE AUTHOR

Miss Boyce is executive secretary of the Tuberculosis and Health Society of St. Louis, Mo., a position which she has held since May, 1948. She is active in the work of the Social Planning Council of St. Louis, having served on numerous committees of the organization, including the executive committee of the Health and Hospital Division. At the present time, she is a member of a committee to study the structure of the council. Her article is a contribution from the Advisory Committee on Public Relations of the National Conference of Tuberculosis Secretaries, of which she is a member.

to share and work to attain its goals.

It is to be expected that the objectives of the health council will vary from time to time. Tuberculosis control may present the greatest need at one point, or it may be the care of the chronically ill, or again it may be the need for a new service in venereal disease. No matter what the specific problem is, the council's problem becomes our problem just as we believe tuberculosis is everybody's problem.

Helps Solve Problems

In St. Louis we have been able by working through the Social Planning Council, which is our health council, to solve some of our problems. For example, during the past few years, one third of the beds at Koch Hospital, our municipal tuberculosis sanatorium, have been unoccupied. They could not be used because there were not enough nurses in the institution to care for the patients. What did we do? Through the Social Planning Council a special committee, representing many community groups, went to work on the problem and within a few months a differential in salaries for nurses at this hospital was secured. The staff of nurses has now been doubled, the hospital beds have been opened, and the waiting lists reduced.

On other occasions we were able, through the health council, to focus the attention of the public on strengthening the health services offered by the official health agency. The Social Planning Council cooperating with the city health commissioner invited Dr. Roscoe P. Kandal of the American Public Health Association to survey St. Louis health services. Dr. Kandal made his study in November, 1949. In December, at a regular delegates' meeting of the health council, the results of this study were made known. Dr. Kandal set forth many needs, the most important among them being, (1) the establishment of mental health clinics and (2) the securing of services of a tuberculosis controller. Following this meeting, the membership of the council, working with other civic groups, was instrumental in securing the release of local city funds which in turn made it possible to secure federal funds for mental health clinics. With these funds the clinics are now being established and this important service will be provided.

Likewise, other groups have joined together to assist the health department in securing the services of a tuberculosis controller. The position has now been placed in the health department budget for the year 1950-51 and has the public support of the mayor.

A rehabilitation project set up as a demonstration at the city's tuberculosis hospital has also been worked out through the health council. In this case all those agencies which provide the type of service needed in such a program were called together by the health council. The project was planned and each service has been included by a cooperative arrangement. In some instances agencies are contributing funds while others are making staff service available. Here again both the official and the voluntary agencies are cooperating not only to make the project possible, but are also meeting regularly to follow the progress being made.

At the present time, the health council is surveying community inadequacies in social service, nursing education, general health education, and the broad phases of tuberculosis control. So by working hand in hand with the Social Planning Council, we believe we are really beating tuberculosis as well as many of our other pressing public health problems.

Financing a Health Council

If the health council is to be effective, it must have funds with which to work. The sources of such funds differ. In many communities, Community Chest may be the sole source of support. In others, support may come by member agencies contributing a pro-rated share of the cost. In other instances, tax funds may be used indirectly; the health department may offer facilities or personnel, or they may contribute secretarial service, meeting places, and office supplies. It is important to remember in connection with budgeting, that the function of the health council as we see it, is only to help in joint community planning. The council that becomes a service agency weakens itself and its member agencies.

Joint Fund Raising

A banding together for community planning through such an organization as the health council in no way obligates any agency to participate in joint fund raising. Many voluntary agencies which have been active members in councils over a period of years have never participated in united fund raising efforts. Actually, through the council, all agencies are better able to appreciate one another's activities, including fund raising. In turn, the community has a better understanding of why some agencies do band together in fund raising while others, due to the nature of their fund raising campaign, prefer to remain independent.

Thus, through coordinated effort, we will move toward our goal. We will find that we are doing less to confuse the very people we attempt to serve as we carry forward the intent of Carlyle's familiar sentence, "Our main business is not to see what lies dimly at a distance, but to do what lies clearly at hand."

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NEW TB HOSPITAL

Plans for a $2,000,000 tuberculosis hospital at the Philadelphia (Pa.) State Hospital at Byberry have been approved by the General State Authority, according to the Pennsylvania Tuberculosis and Health Society. The new building will provide facilities for treatment of 300 tuberculosis patients.

TB Assn. Evaluates Board Meetings

Survey by Board Members of Greater Hartford (Conn.) Tuberculosis and Public Health Society Results in Increased Emphasis on Program

By P. CORBIN KOHN*

AN evaluation of the meetings of the board of directors of the Greater Hartford (Conn.) Tuberculosis and Public Health Society was made this spring as part of the program of self-survey which has been conducted by the society over the past three years.

Hartford is one of two pilot centers set up by the National Tuberculosis Association for study as part of the educational survey begun in 1944. The other center is Denver, Colo.

Since one of the fundamental purposes of the society is the promotion of public awareness of tuberculosis and related problems, members of the board felt that they themselves must be adequately informed in order to play their proper role in the fulfillment of this purpose.

Meetings Studied

Board meetings have been held at a set time for many years and have been limited by common consent to exactly one hour. We have felt that some of the matters on which we were spending time were extraneous or relatively unimportant and that, perhaps, we were not getting to the meat of the problems and to discussing the program of the society as much as we should. Therefore, we welcomed the opportunity to study the meetings and see what we were accomplishing in them.

A committee of nine members of the 45-member board was appointed for this project and charged with the responsibility of preparing a suitable questionnaire for board members. Each committee member was given the task of obtaining answers from four members of the board in addition to himself.

A general planning meeting was held in December, 1949, at which a suggested list of questions was presented by the field secretary of the NTA Pilot Study. The questions were as follows:

1. How did you happen to become interested in the problem of tuberculosis?

2. Do you recall the steps that led to your becoming a board member?

3. What do you think board meetings are for? (List all functions in the order of their importance.)

The following list of functions or, better still, a list drawn up by the committee, was suggested to start board members thinking in terms of functions.

(a) To listen to committee reports and accept or reject them.

(b) To learn how the money is being spent.

(c) To learn about the tuberculosis and other related health problems in the community.

(d) To take an active interest in the problems and by participating in discussions help reach solutions of them.

(e) To be willing to go out and do the job that is necessary for the solving of problems if they are such that active help is needed.

4. In your opinion, of the functions that you have listed, which are being carried out at the board meetings at the present time?

5. Do you feel that you are close to the tuberculosis problems of the community and aware of the society's part in the total program as a result of board meetings?

(a) Do you know what is meant by the tuberculosis control program of the community—what services and facilities it includes?

(b) Suppose someone asked you what the society does, what would you tell them?

(c) What understanding do you have of the state and national association programs in which you participate?

6. Is the atmosphere of the board meetings such that you feel at ease and at liberty to speak?

7. Do one or two persons do most of the talking for the group?

8. Do one or two persons do most of the thinking for the group?

9. How often do you think the board should meet? At what time of day should it meet? How long should the meetings last?

10. Do you have any suggestions to offer that might make the board meetings more vital?

Study Minutes

As a separate part of the project, it was suggested that the board meetings of the past two years be evaluated by a thorough study of the minutes. The following points were suggested for this:

1. List committee reports given at board meetings under (a) program and (b) other activities.

2. List subjects about which there has been discussion, but no decision reached under (a) program and (b) other activities.

3. List decisions that the board has reached in its meetings under matters of (a) program and (b) other activities.

4. List follow-up activities which have required the time and effort of the board members over and above that of time spent in board meetings, either as individuals or as a group under (a) program and (b) other activities.

The committee went over these questions with a great deal of care. It was felt that some of them were more detailed than necessary, that some could be combined, and that some had already been taken care of, such as question 9. Therefore, the committee decided to adapt

* Mr. Kohn is a member of the board of directors of the Greater Hartford (Conn.) Tuberculosis and Public Health Society and a member of the board's evaluation committee.

these questions to our local needs and delegated this chore to three of its members. The group met and drew up the following questions:

1. How did you become interested in the society and its work?

2. Do the board meetings keep you sufficiently informed about the progress and problems of the work of the society? For example, are you sufficiently aware of present-time developments of BCG vaccine, the shortage of nurses in tuberculosis hospitals in Connecticut and the waiting list of patients for treatment, the relationship of our society to Hartford's general social welfare and also the Multiple Fund Review Council, coordination of our work with that of other health organizations, and with tuberculosis statistics in general?

3. What suggestions do you have to make the board meetings more vital? Would you be in favor, for instance, of timing board meetings to allow ten minutes at the end of each meeting for a discussion of a pertinent subject.

Fitted Local Situation

Although the latter questions were not as detailed as the original list, we felt that they fitted our own situation more appropriately. It was recognized that they were not quite as searching as they might have been and that Questions 2 and 3 were to some extent "leading," but these characteristics were not deemed disadvantageous in view of the subjective nature of the inquiry.

The list of questions was then sent with a covering letter from the chairman of our committee to each board member, asking him or her to be prepared to answer the questions when interviewed by a member of the committee. This personal interview took place within a week or two and the results were sent to headquarters.

Answers were collated, first by members of the committee and later by the field secretary of the NTA, in order to make a thorough analysis of the results.

The replies to Question 1 showed that 15 directors became interested in the work of the society through acquaintance with a board member or through being asked to become a corporate or board member. Five became interested because of volunteer service in connection with X-raying or tuberculin testing programs or Seal Sale, four had been working with other health and welfare agencies, and two had served on the board of a related agency.

In response to Question 2, a majority of the members felt that board meetings should be more concerned with program activities and less with organizational details. Specific ways of accomplishing this were suggested by many members, such as requiring committee chairmen to prepare their reports more thoroughly and to present both sides of a question in order that the board members would have a better background on which to base decisions. Other suggestions were that short talks be given from time to time by staff members on their specific work and that detailed reports be submitted to members in advance of meetings.

Question 3 elicited many constructive suggestions. All but two of those answering the questionnaire approved of allowing ten minutes at the conclusion of each meeting for discussion or for a talk on a pertinent subject. This practice was adopted and has already been found to be very productive of increased activity and interest.

One Year's Minutes

In addition to the questionnaire, one of the members of the committee was appointed to analyze the board minutes of the previous fiscal year. This report brought out several valuable points on which specific recommendations have been made to our board of directors.

The analysis showed that our average attendance had been very low, although it had been the general impression of the officers that attendance was good. Of course, a few meetings at which for varying reasons the attendance was unusually low pulled down the average, but we cannot offer that as a complete excuse for our showing.

An analysis was made also of the subjects discussed at the meetings. We were shocked to discover that in the number of items discussed, 60 per cent of the business of the board was devoted to the more or less formal procedures pertaining to organization and only 40 per cent to the real objectives or program of the society.

There was no way of determining the amount of time spent on each item of business, but it would seem clear that an undue amount had been spent on the mechanics of organization.

Some suggestions made as a result of this analysis concerned provisions of the constitution and by-laws, the proper form for recording resolutions, and the care of the minute book. These would not be of general interest and need not be discussed here, except to suggest that it is important to insure that the minutes adequately record the doings of the board.

We believe that much good has been gleaned from this study. The society has received many carefully thought-out suggestions about its work, members have been made to feel their responsibilities to the organization, and many of the suggestions received have already been put into practical effect. Perhaps other associations can benefit from carrying out a similar evaluation project.

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MORE TB BEDS

The San Francisco Board of Supervisors, acting on an urgent plea by the San Francisco Tuberculosis Association, has approved a resolution to finance the opening and operation of two additional tuberculosis wards at the San Francisco Hospital.

Opening of the wards will give the county 80 more beds for tuberculosis and permit the hospitalization of 72 men and women, acutely ill with active tuberculosis, who have been waiting for care.

NTA Retirements

S. M. Sharpe, Miss Dornin, and Mrs. Paterson leave staff after long service

Three of the National Tuberculosis Association's oldest employees in terms of service were honored by the Association's Board of Directors in resolutions of appreciation prior to their retirement May 31. They are S. M. Sharpe, business manager; Miss Margaret Dornin, accountant, and Mrs. Elizabeth M. Paterson, administrative assistant.

Expressing its "deep appreciation and gratitude" to Mr. Sharpe for his "loyal and constructive work," the resolution said that during his many years of service he had not limited his interest in the Association to business management but had been concerned with the overall program, especially in how educational material fits into implementation of program.

Mr. Sharpe handled the business affairs of the NTA from June, 1920, established the business and supply services, and worked out machinery for financing supplies to the state associations.

A native Texan and a civil engineer by profession, Mr. Sharpe entered the tuberculosis movement as a field worker for the Christmas Seal Sale Service.

Miss Dornin, a member of the NTA staff since September, 1919, had served as accountant since 1924. The resolution pointed out that she had developed excellent working relationships with the affiliated associations, using in all her work "fine judgment, caution, and wisdom."

Coming into the Association when the office was still using a single entry bookkeeping system, Miss Dornin developed the accounting machinery to handle increased income in cooperation with the treasurer and auditor, aided the state associations in establishing their own accounting systems, and served them in an advisory capacity.

The Board commended Mrs. Paterson, a member of the staff since 1920, for her "versatile and efficient work," calling it "varied in nature, great in volume, and high in efficiency."

Beginning her work with the Association as a staff stenographer, Mrs. Paterson served in institutional and advisory services and as secretary to Dr. Philip Jacobs for several years. In 1929, she became secretary to Dr. Kendall Emerson, then managing director, and later became administrative assistant. Since 1938 she had served as recording secretary for the National Conference of Tuberculosis Secretaries, and as administrative assistant for the American Trudeau Society. Last December, she married Dr. Robert G. Paterson of Columbus, Ohio, NTA archivist.

LEAVES NTA

FABIAN BACHRACH PHOTO

S. M. SHARPE

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A touch of mystery was added to a story about an X-ray survey for tuberculosis in Marshall, Mich., by this headline in the *Albion* (Mich.) *Recorder*: "14 Suspicious Chests Found in Marshall."—*Editor and Publisher.*

IDAHO IS PLANNING MASS X-RAY PROGRAM

Assurance of a mass chest X-ray program in Idaho within the next year has been given by the appropriation of $85,000 by a special session of the State Legislature, according to the Idaho Anti-Tuberculosis Association.

The project will be conducted by the Idaho Department of Public Health, the Idaho Anti-Tuberculosis Association, county health units, and county tuberculosis associations.

Co-sponsors of the project will include the Idaho State Medical Association, Idaho Division of the American Cancer Society, Idaho Public Health Association, Idaho Congress of Parents and Teachers, Idaho State Federation of Women's Clubs, and the Federated Farm Bureau.

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HOUSE, TRUST FUND BENEFIT TB PATIENTS

The Saranac Lake Study and Craft Guild, Saranac Lake, N.Y., has been given the Prescott House for use as a rehabilitation headquarters, according to *Friday Letter* of the State Committee on Tuberculosis and Public Health of the State Charities Aid Association.

Friday Letter also reports that the income from a $45,000 Prescott trust fund is being made available to the Saranac Lake Tuberculosis Society for the benefit of patients with tuberculosis.

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NEW TB HOSPITAL

The Texas State Board of Health has granted $300,000 to match funds provided by the late Mrs. Rosa Zeigler to construct and equip a 72-bed hospital for tuberculosis patients at the University of Texas Medical Branch, Galveston.

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The World Medical Association will meet in New York City, Oct. 17-19, 1950, the organization has announced.

Int'l Union To Meet

Copenhagen conference first since 1937—NTA-ATS members featured speakers

Representatives of the National Tuberculosis Association and its medical section, the American Trudeau Society, will take a leading part in the 11th Conference of the International Union Against Tuberculosis scheduled for Sept. 3-6 in Copenhagen, Denmark.

The conference will be the first to be held since 1937 although the Union's governing bodies, the Council and the Executive Committee, have both met yearly since 1947. The Executive Committee also met in 1946.

NTA Representatives

The NTA is represented on the Council by Dr. Kendall Emerson, former managing director; Dr. Herbert L. Mantz, past president; Dr. Esmond R. Long, director of research and therapy; Dr. H. Corwin Hinshaw, former president, ATS, and Dr. James E. Perkins, managing director. Dr. Perkins is also a member of the Executive Committee.

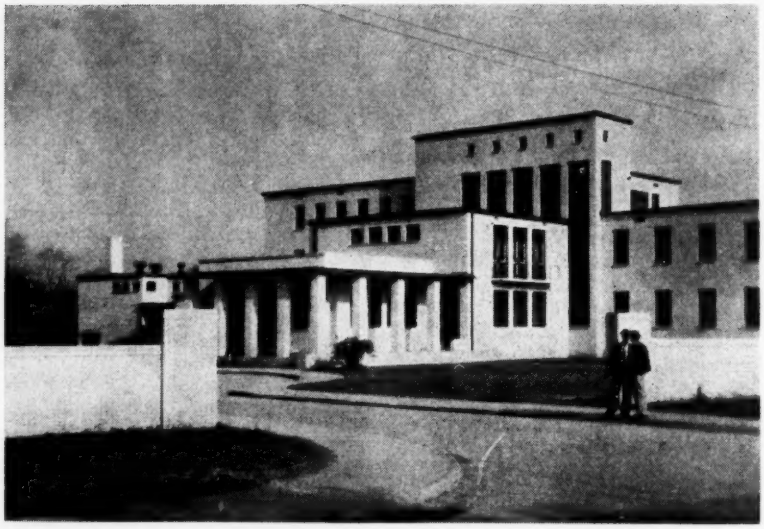
Speakers from 19 countries will report at the scientific sessions and representation is expected from more than 40. Dr. K. A. Jensen of the University Institute of General Pathology, University of Copenhagen, will take office as president of the Union and will preside at the Conference.

On the first day, Dr. Long will be the main speaker at a session on the sensitivity and resistance of the tubercle bacillus to chemotherapeutic agents. Dr. Walsh McDermott, managing editor of the official ATS publication, *The American Review of Tuberculosis*, will speak at the same session.

Dr. Kirby S. Howlett, Jr., past president of the ATS, will speak the following day when collapse therapy, particularly pneumothorax, will be discussed.

Speakers representing the United States at the closing session, on the relative importance of measures required in countries where tuberculosis control is still in its earlier stages, will include Dr. Robert J. Anderson, chief, Division of Tuberculosis, Public Health Service, a member of the ATS Executive Committee, and Dr. Leo V. Schneider, chief, Tuberculosis Control Section, Tuberculosis Division, Veterans Administration, a former NTA committee member.

NEW TUBERCULOSIS HOSPITAL



New 104-bed unit at Lafayette, La., for the treatment of tuberculosis. The unit is part of Charity Hospital and will serve 11 thickly-populated counties in south and southwest Louisiana. Richard Koch of New Orleans was the architect.

LOUISIANA OPENS NEW TB UNIT AT LAFAYETTE

Opening of Lafayette Charity Hospital's $1,200,000 tuberculosis unit in February marked Louisiana's latest advance in the fight against tuberculosis. While the state is still short an estimated 542 beds for the disease, opening of the 104-bed unit brings the number of beds to approximately 1,300.

Planned to serve 11 thickly-populated parishes in south and southwestern portions of the state, the hospital will care for both white and Negro patients. Two of its three floors are comprised of private rooms and small wards, while the third is made up of an X-ray room, dental office, pneumothorax treatment center, laboratory, and other facilities.

Examination of patients will be carried out by Charity Hospital's out-patient clinic and major surgery and other treatments will be performed at Charity Hospital.

Dr. J. O. Duhon, superintendent of Charity Hospital, is in charge of the new unit and Dr. J. Harvey Rester, Jr., is resident physician.

★

INT'L TB CAMPAIGN

A three-year-old Pakistani girl, tested for tuberculosis early in March at Karachi, was the 20,000,000th person to be examined through the international tuberculosis campaign carried on by the United Nations International Children's Emergency Fund during the past two years.

Approximately half of those examined have been vaccinated with BCG as a preventive measure.

THE PRESIDENTS' COLUMN

By GROVER C. BELLINGER, M.D., President, ATS

THE control of tuberculosis, as developed by the National Tuberculosis Association during the past 45 years, has set a pattern for programs for the solution of a number of major health problems of our time.

Sometimes we forget that an effective health program must be planned to catch the newly arrived as well as the newly awakened individuals in the community.

Educational Programs

I am particularly impressed with the necessity of keeping our educational programs for patients and the public carefully keyed to the natural history of tuberculosis as we go along with our X-ray surveys. The records of some tuberculosis hospitals over a period of years show a steady decrease in the percentage of minimal case admissions, although their areas are covered by surveys reporting percentages of minimal cases ranging around 60 to 80.

When tuberculin testing was a major screening process, we took particular pains to explain to the patient and the public that the reactor need not fear the positive reaction itself and we hastened to advise having chest films taken. We explained that 85 to 90 per cent of the important tuberculosis occurs in the chest and that if the chest film showed "nothing," the test would be understood as showing infection which had not developed into disease of practical importance. However, we used the incidence of tuberculin reactors in a family group, a contact group, or in community or school groups to point out the greater or lesser proportion of communicable tuberculosis which might be present.

A major weakness now is that the patients comprising the 70 per cent or so of minimal cases seen in the films are not going to sanatoriums, nor are they under any other plan of adequate care, at least not in many of the survey districts. Are we practicing good preventive or clinical medicine at this point of discovery? It seems to me that the contact group that produces a positive film, or the community group that produces several positive films, deserves our prompt attention with our best possible array of weapons.

The message notifying the patient of the need for further study should be given in such a way as to clear up any anxiety or doubt as to its meaning. The chance to offer understanding and encouragement to the ones who must face a diagnosis of disease is but an introduction to the education that is needed to guide them through the early stages of management and lead them to becoming good cooperative patients.

Other Health Problems

While our primary objective is the control of tuberculosis, the skills which we have developed in the management of health problems should be applied to those conditions which come before us, insofar as may be necessary for the best possible service to the community which supports our work. Such service should be rendered by the use of health education aimed at the several chest conditions which may be discovered through the survey. Definitive diagnosis for diseases other than tuberculosis should not be developed by our organization, however, except in those communities where we have been selected for such a purpose.

We should use some plan that brings those with non-tuberculous conditions to centers where comprehensive experience in diagnosis and management is available.

The early diagnosis and early treatment of tuberculosis is our greatest challenge at the present time. Early lesions and small lesions are often not inconsistent with good general health. We need to know about them, not only of their presence but of their meaning to the individual and his contacts. Our whole program needs constant reviewing, not only to maintain its basic principles of control but also to develop more and more in its technical skills and in understanding. With such progress, its application for the benefit of world health must have our constant attention.

Best Counsel Necessary

Without the best of counsel, there is too great a risk that patients with minimal disease may develop a false sense of security. When one feels well it is easy to think that enough has already been done and that the well-coordinated follow-up is unnecessary. If the patient with minimal tuberculosis goes to the sanatorium, he is quite apt to feel entirely well, and all concerned may find it difficult to believe that a complete cure has not been attained in a period of four to six months. Also, it is possible and quite probable that the usual length of hospitalization for a minimal case of tuberculosis may be passed through without a positive sputum. However, the amount of disease which may develop in a year or so after the patient has left the sanatorium is appalling.

The long, silent period of clinical disease is the time when the doctor, the nurse, and the well informed family, neighbors, and friends should be walking side by side with

the patient, thinking and planning with him.

The skilled hands that direct the survey have the obligation and the privilege of guiding and indoctrinating the patient who has a positive film so that he may carry through to a successful conclusion. We cannot consider our program complete unless we use our resources at the point where his disease is first diagnosed.

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CLEVELAND HOSPITALS WILL X-RAY PATIENTS

A program to give chest X-rays to 115,000 patients yearly will be launched by eight Cleveland (Ohio) hospitals in the near future, according to the Ohio Tuberculosis and Health Association.

The program is under the sponsorship of the Cleveland Hospital Council and the Anti-Tuberculosis League of Cleveland and Cuyahoga County.

The eight hospitals already equipped for taking the films are Charity, St. Luke's, Huron Road, City, St. Alexis, Lakeside, Fairview, and Lutheran. Others are expected to join the program soon.

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MOBILE X-RAY GIVEN BY TB ASSOCIATION

The Detroit (Mich.) Health Department has its first mobile X-ray unit, a gift from the Tuberculosis and Health Society of Wayne County, early in April.

The unit will be operated by the department and its use directed by Dr. Paul T. Chapman, Detroit tuberculosis controller. The tuberculosis society will assist with the planning and promotion of the surveys conducted with the new equipment.

★

AMA TO MEET

The American Medical Association will hold its annual meeting at San Francisco, Calif., June 26-30.

HE'S NO DUMMY!

Wooden screen and radio star Charlie McCarthy, accompanied by his sidekick Edgar Bergen, gets a free chest film at the launching of the Los Angeles County X-ray Survey on March 22. Tested for TB and termites, Charlie's report was negative.

LOS ANGELES COUNTY SURVEY IS UNDER WAY

Nearly 300,000 free chest X-rays were made during the first six weeks of the Los Angeles County X-ray campaign which opened March 22, according to the Los Angeles County Survey Foundation.

Through the program, operated by the foundation, more than 3,000,000 persons 15 years of age and over will be examined during the current year. A million and a half of these persons will be reached through a business and industry committee, lately set up within the foundation's structure, representing 15 major business and industrial divisions in the county.

Additional thousands will be reached through a schools committee which is arranging for surveys of students, faculty, and other school personnel in every university, college, and high school—both public and parochial—in the county.

Thirty-three units were in operation at the end of the sixth week and will be joined by seven others.

Financed by tax monies and Christmas Seal funds, the program is sponsored by the Los Angeles County Medical and Osteopathic Associations; Los Angeles County Health Department; Los Angeles, Pasadena, Beverly Hills, Vernon, and Long Beach City Health Departments; Los Angeles County, Long Beach, and Pasadena Tuberculosis and Health Associations; California State Department of Public Health, California Tuberculosis and Health Association, and the U.S. Public Health Service.

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SOCIAL SERVICE

The Social Service Department at the Municipal Tuberculosis Sanitarium, Chicago, operated by the Tuberculosis Institute of Chicago and Cook County on a demonstration basis since October, 1948, has been incorporated in the hospital's 1950 budget, according to the institute.

TB Veterans

Short-staffed VA hospitals key to lack of beds for tuberculous veterans

By M. J. PLISHNER*

Waiting lists and empty tuberculosis beds in Veterans Administration hospitals at the end of February were almost equal in number, according to the latest figures obtained from the VA.

The waiting list for tuberculous veterans seeking admission to VA hospitals on Feb. 28, 1950, amounted to 2,379. At the same time, there were 2,370 VA-owned tuberculosis beds unavailable for patients due to either lack of personnel, current alterations, or renovations. The lack of personnel accounted for the unavailability of 1,537 of these beds.

Lack of Staff Critical

Review of the list of empty tuberculosis beds, tabulated by medical supervision areas, shows that if the unavailable beds were properly located and could be staffed, the waiting list in four of these six VA areas could be wiped out and still leave 917 excess beds. Approximately one-third of the waiting list in the two remaining areas could also be liquidated by this means, according to the report made by top-level medical personnel in the Veterans Administration.

More staff, more than more beds, is the critical need at this time. Recent cuts in VA staff, which have been at least temporarily suspended insofar as medical personnel are concerned, would further intensify the empty bed situation.

Practically all the tuberculous veterans on the waiting list noted above were non-service connected cases of the disease. According to the laws now applicable, veterans whose tuberculosis is adjudged to have been incurred or aggravated in military service have a first priority on VA beds, but any veteran with a non-service connected case of tuberculosis may be treated in a VA hospital to the extent that other beds are available. Last year, of 13,000 veterans treated for tuberculosis by the VA, about 8,000 were non-service connected cases.

The House of Representatives recently passed H.R. 7740 and sent it to the Senate, which has not yet acted on this bill. The legislation would extend the period for presuming the disease to have been "service connected." If passed in its present form, the law would provide that a veteran with active pulmonary tuberculosis developing a 10 per cent disability or more within three years from date of separation from the service shall be deemed to have a "service connected" case of the disease. The effect of such regulations would be to expand immediately the number eligible for mandatory admission.

It is estimated that a peak load of 20,000 veterans with tuberculosis will be occupying VA beds by 1955. The anticipated demand will level off about 1960, after which a fairly steady load of between 15,000 and 18,000 cases would be constantly hospitalized under the provisions of existing laws.

* Chief, Veterans Services, NTA

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TO BUY X-RAY UNIT

Funds for the purchase of an X-ray unit have been allocated by the Idaho Anti-Tuberculosis Association and county associations in the state, according to the association's *News Letter*.

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APHA TO MEET

The American Public Health Association will hold its annual meeting in St. Louis, Mo., Oct. 30-Nov. 3.

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Scientists at the General Electric Research Laboratory have developed an X-ray microscope which will enable them to see small internal details of germs, cells, and other microscopic life. — *National Society for Medical Research*

OFFERS FELLOWSHIPS IN HEALTH EDUCATION

Fellowships for graduate training in health education are being offered by the National Tuberculosis Association for co-sponsorship by state and local tuberculosis associations for a twelve-month period beginning in September.

Offered on a matching basis, the fellowships will include nine months of academic work and three months of supervised field training leading to a Master of Public Health degree, or to other Masters' degrees in health education.

The course will be given at the following accredited schools: University of California School of Public Health, Harvard University School of Public Health, University of Michigan School of Public Health, University of North Carolina School of Public Health, and Yale University School of Medicine, Department of Public Health.

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AMA OPENS NEW LAB

Establishment of a new microbiology laboratory at the headquarters of the American Medical Association has been announced by the AMA. Investigations will be made of the biologic, bacteriologic, immunologic, and antibiotic properties of various products which are offered to the medical profession and the public.

Items to be studied include cosmetics, foods, germicides, antiseptics, beverages, serums, and vaccines.

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NEW X-RAY UNIT

Inauguration of a free "curbside" chest X-ray service for workers in small industrial plants has been announced by the San Francisco (Calif.) Tuberculosis Association.

The service is made possible by the acquisition of a new small film unit housed in a truck. Equipment has been pared down to a minimum and the truck itself is small enough to be parked in congested sections of the city without difficulty.

NEW HEALTH FACILITIES SET FOR PUERTO RICO

Construction of four new health centers and hospitals in Puerto Rico under the federal hospital program has been approved by the U.S. Public Health Service. The insular government will pay one-third of the cost of each.

Plans call for a $156,000 health center in Camuy, a 38-bed general hospital and health center in San German to cost $300,000, alteration of the existing health center and the construction of a 22-bed hospital in Vega Baja to cost $180,000, and a $112,500 new health center in Hormigueros.

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X-RAY PROGRAMS

More than 33,000 residents of Kane County, Ill., were X-rayed by the Kane County Tuberculosis Association and Springbrook Sanatorium during 1949, according to the annual report of the sanatorium.

Also in Illinois, the Lee County Tuberculosis Association took 899 chest X-rays of patient admissions and personnel of the Dixon Hospital last year.

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FIVE-WEEK SURVEY

A five-week, city-wide X-ray survey opened in Allentown, Pa., May 1, under the auspices of the Bureau of Tuberculosis Control, Pennsylvania State Department of Health, the Lehigh County Medical Society, the Lehigh County Tuberculosis and Health Society, and the Allentown Junior Chamber of Commerce.

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NEW TWO-COUNTY SAN

Completion of the main building of a modern 142-bed tuberculosis hospital at Springville, Calif., was announced recently.

Built and equipped at a cost of more than $700,000, the hospital will serve two counties, Tulare and Kings, and will bring the counties' total tuberculosis beds up to 255.

TURKEY TO ESTABLISH TB TRAINING CENTER

The Turkish Health Ministry has allocated 200,000 Turkish pounds toward the establishment of an anti-tuberculosis demonstration and training center to be constructed at Istanbul. A similar sum will be provided by the Anti-Tuberculosis League of Istanbul.

The United Nations World Health Organization will provide technical guidance and a team of tuberculosis experts to supervise the proposed center. The principal aim is to enable doctors, nurses, X-ray and laboratory technicians to be trained in the most modern methods of fighting tuberculosis with a view to strengthening and expanding tuberculosis control services throughout Turkey.

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X-RAY STATE EMPLOYEES

The New York State Department of Health has begun a mass chest X-ray program for about 40,000 state employees. The first such service to be given since 1946, the survey is being conducted on a voluntary basis.

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BREAKS OWN RECORD

The Case-Finding Committee of the San Francisco (Calif.) Tuberculosis Association reports a record-breaking year in 1949, with a total of 93,606 free chest X-rays taken during that period. The total for 1948 was 75,152.

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HEALTH CAMP CLOSED

Discontinuance of Camp Wanzer, a summer health camp for undernourished children, in favor of a more direct program for finding and controlling tuberculosis has been announced by the South Dakota Tuberculosis Association. The camp has been operated by the association since 1923.

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On May 9 Cuba became the seventieth country to join the United Nations World Health Organization. —*New York Times.*

NEW HEALTH CENTER NEARS COMPLETION

The first public health center to be constructed in Minnesota under the Hospital Survey and Construction program is nearing completion, according to *Newsletter* of the Division of Tuberculosis, U.S. Public Health Service.

Situated in downtown Rochester, the two-story building will house the offices, laboratory, and clinic facilities of the Rochester-Olmstead County Health Unit and District III of the Minnesota Department of Health, as well as city welfare offices.

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MARRIAGE BILL KILLED

A bill which would have barred the marriage of persons with tuberculosis in New York State has been killed, according to *The New York Times.* Described as an attempted "roadblock in the path of romance," the bill would have required applicants for marriage licenses to submit proof they were free from tuberculosis as well as venereal disease.

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HOSPITAL X-RAY

In line with a new personnel policy, some 650 employees of Mt. Carmel Hospital, Columbus, Ohio, are to be chest X-rayed, according to the Ohio Tuberculosis and Health Association. A new program of X-raying all admissions will begin shortly at White Cross, another large general hospital in Columbus, the association states.

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NIGHT SURVEY

Three thousand employees of the Shenango Pottery, Lawrence County (Pa.) were recently X-rayed by the Lawrence County Tuberculosis Society. According to the society, X-raying of those on the night shift was done between the hours of midnight and three in the morning.

BOOKS

The following books may be purchased through the BULLETIN at the prices listed:

Current Therapy, 1950. Latest approved Methods of Treatment for the Practicing Physician, Edited by Howard F. Conn, M.D. Consulting editors: Drs. M. Edward Davis, Vincent J. Derbes, Garfield G. Duncan, Hugh J. Jewett, William J. Kerr, Perrin H. Long, H. Houston Merrit, Paul A. O'Leary, Walter L. Palmer, Hobart A. Reimann, Cyrus C. Sturgis, Robert H. Williams. Hard Cover. 736 pages with index. Published by W. B. Saunders Company, Philadelphia, Pa., 1950. Price, $10.00.

The title and the list of consulting editors are an adequate description of this book.

BCG Vaccination in Theory and Practice, by K. Neville Irvine, D.M., M.A., B.Ch. Oxon., M.R.C.S. Eng., L.R.C.P. Lond., with foreword by Konrad Birkhaug, B.A., M.Sc., M.D., F.A.C.P. First Edition. Hard cover, 130 pages including index. Published by Charles C. Thomas, Springfield, Ill., 1949. Price, $3.00.

This is a comprehensive review of literature on BCG with references and a foreword by Konrad Birkhaug, director of the BCG Laboratory, New York State Department of Health. It is a timely and important book.

The Social Welfare Forum. Official Proceedings, 76th Annual Meeting National Conference of Social Work, Cleveland, Ohio, June 12-17, 1949. First edition. Hard cover. Published by Columbia University Press, New York, N.Y., Price, $4.25.

The theme of the conference which is here reported was: "Toward a Better Life—the Positive Role of Social Work in Resolving Social Conflict and Attaining Social Goals." For social workers and for those whose professional activities and interests are a part of the social structure this book is a "must."

Community Health Organization, by Ira V. Hiscock, M.P.H., Sc.D., chairman, Department of Public Health, Yale University, New Haven, Conn. Fourth Edition. Hard cover. 278 pages with index and charts. Published by the Commonwealth Fund, New York, N. Y., 1950. Price, $2.75.

This is the latest edition of a classic in the public health field. Most of the chapters have been rewritten and new material has been added. This book is required reading for all public health workers.

The Healing Touch, by Harley Williams. First edition. Hardcover, 408 pages with index and references. Published by Jonathan Cape. Thirty Bedford Square, London, England, 1949. Price, 15 shillings (approximately $3.00).

This account of the lives and influences of some of the figures responsible for forming modern concepts of medical practice is a welcome addition to any library. Readers in this country will find the chapters on Victorian medical men and Florence Nightingale more rewarding than those on Cushing and the Mayo brothers.

Occupational Therapy, Principles and Practice, edited by William Rush Dunton, Jr., M.D., and Sidney Licht, M.D. Hard cover. 321 pages with index and line illustrations. Published by Charles C. Thomas, Springfield, Ill., 1950. Price, $6.00.

The editors of this volume have enlisted the aid of others, including Andrew L. Banyai, M.D., F.A.C.P., F.C.C.P.; Walter E. Barton, M.D.; Ruth W. Brunyate, O.T.R.; John Eisele Davis, A.M., Sc.D.; Phyllis Lyttleton, C.S.P., M.O.A.T.; Winthrop Morgan Phelps, M.D.; Jerome M. Schneck, M.D.; Alfred P. Solomon, M.D., and Paul Dudley White, M.D., to produce a general manual on this subject for physicians. The range of this study, which includes a chapter on tuberculosis by Dr. Banyai, is extensive. The materials included constitute a valuable addition to the literature of this phase of treatment.

PEOPLE

California—Dr. R. D. Thompson, past president of the National Tuberculosis Association, has resigned as medical director of La Vina Sanatorium, La Vina, to become first medical director of Florida's new state sanatorium at Lantana. Dr. Thompson is succeeded by Dr. William H. Oatway, Jr., most recently research resident at Barlow Sanatorium, Los Angeles. A native of Wisconsin, Dr. Oatway spent several years in private practice at Tucson, Ariz., and has served on the staffs of Trudeau Sanatorium, Saranac Lake, N.Y.; Laurel Heights Sanatorium, Shelton, Conn., and Wisconsin General Hospital, Madison, where for seven years he was in charge of the chest service.

Florida—Dewey Knight has been named president of the Florida Tuberculosis and Health Association. Serving with Mr. Knight are Walter L. McJordan, vice president; Mrs. Basil E. Kenney, Sr., secretary, and G. W. Frazier, treasurer.

Mrs. Elizabeth Roose is the new president of the Florida Conference of Tuberculosis Secretaries. Mrs. Lou McWhorter is vice president, and Miss Peggy Pemble, secretary-treasurer.

Dr. Lawrence H. Kingsbury will head the Florida Trudeau Society. Dr. DeWitt Daughtry will serve as vice president, and Dr. C. M. Sharp, as secretary-treasurer.

Georgia—Mrs. Florence Bell, former executive secretary of the Atlanta Tuberculosis Association, died May 10. Mrs. Bell had served as executive of the association from September, 1941, until her retirement in April, 1946. Prior to 1941 she had been a field worker for the Indiana Tuberculosis Association, executive secretary of the Duval County (Fla.) Tuberculosis Association, and for eight years Christmas Seal Sale field adviser for the National Tuberculosis Association.

PEOPLE

Illinois—John E. Egdorf, director of rehabilitation, Tuberculosis Institute of Chicago and Cook County, was named executive secretary of the organization April 1. Mr. Egdorf was with the Illinois Tuberculosis Association as field representative (1939-1941) and served as executive secretary of the Will County Tuberculosis Association (1941-1942). For one year he was chief of physical restoration, Illinois State Division of Vocational Rehabilitation before joining the institute staff in 1947 as consultant in rehabilitation.

Miss Etta Harkness has been named rehabilitation coordinator of the McLean-Tazewell County rehabilitation project. Setting up of the project follows the dissolution of a tri-county program in McLean, Champaign, and Vermilion Counties and a bi-county program in McDonough and Tazewell Counties. Miss Marion Keoughan will coordinate the program in McDonough County and Miss Eunice Ford in Champaign and Vermilion Counties.

Dr. R. S. Harnsback of Edwardsville was recently honored at a testimonial banquet for his more than 50 years as a physician. He is treasurer of the Madison County Tuberculosis Association and has served on the association's board of directors for several years.

Mrs. Elizabeth K. Imhoff, director of Seal Sale, Tuberculosis Institute of Chicago and Cook County, was married on April 18 to Clemens Koehler.

Dr. Frank Davis is the new president of the Public Health Nursing and Tuberculosis Association of Sangamon County. Other new officers are Michael Eckstein, first vice president; Miss Lucy Williams, second vice president; Lawrence Meiklejohn, treasurer, and Mrs. Russell Lindburg, secretary.

Indiana—Mrs. Glenn Reister has succeeded Mrs. Martha Cavanaugh as executive secretary of the Washington County Tuberculosis Association.

Michigan—Ernest C. Bowen has been named president of the Tuberculosis and Health Society of Wayne County. Other new officers are William E. Shane, first vice president; James W. Parker, second vice president; Walter Guibord, treasurer; the Rev. Bernard R. Crowley, secretary, and Kenneth Murray, counsel.

Missouri—Benjamin Small has resigned as rehabilitation coordinator at Koch Hospital, St. Louis, to accept the position of assistant to the executive director of the United Jewish Federation, Buffalo, N.Y. Mr. Small, whose services were provided by the Tuberculosis and Health Society of St. Louis, joined the hospital staff in 1947. Dr. Bernard Freedman, assistant medical director of the hospital, will become rehabilitation coordinator.

New Jersey — Dr. John Bennett Morrison, former president of the New Jersey and Essex County Tuberculosis Leagues and for nearly 20 years secretary of the New Jersey State Medical Society, died recently.

New York—A. W. Dalton, associate, Program Development, National Tuberculosis Association, succeeded Mrs. Elizabeth M. Paterson as administrative assistant to Dr. James E. Perkins, managing director, June 1.

Joseph H. Bishop, executive secretary of the Iowa Tuberculosis Association, joined the staff of the NTA on June 1 as an associate, Program Development.

Fred M. Stein, a former member of the National Tuberculosis Association Board of Directors, died April 25. His age was 76. Mr. Stein, who had served also as a member of the board of the New York Tuberculosis and Health Association, was founder and president for 36 years of the Committee for the Care of the Jewish Tuberculous, and founder of Altro Workshops, a project for the rehabilitation of the tuberculous.

John M. Glenn, one of the original trustees of the Russell Sage Foundation, and a founder of the National Society for the Prevention of Blindness, died April 20 at the age of 91. He had served as a member of the NTA Board of Directors from 1909 to 1917.

North Carolina — Mrs. Dan K. Moore is the president of the newly-organized Jackson County Tuberculosis Association. Serving with Mrs. Moore are C. B. McConnel, vice president; Mrs. Paul Reid, recording secretary, and Mrs. Walter Jones, treasurer.

North Dakota—Dr. Fannie Dunn Quain, founder of the North Dakota Anti-Tuberculosis Association and a member of the National Tuberculosis Association Board of Directors (1927-1939) died recently.

Pennsylvania—Mrs. J. Blair Sutton is the new executive secretary of the Indiana County Tuberculosis Society, succeeding Mrs. Ralph Forester who died recently.

Texas — Dr. Elliott Mendenhall was named president of the Texas Tuberculosis Association at the organization's annual meeting in April. Serving with Dr. Mendenhall are Dr. David McCullough, first vice president; Dr. R. G. McCorkle, second vice president; J. W. Butler, secretary, and Dr. Z. T. Scott, treasurer.

Miss Margaret Hall has been elected president of the Texas Conference of Tuberculosis Secretaries. Other new officers are W. W. Wendt, vice president, and Mrs. Linnie Davidson, secretary-treasurer.

Dr. Tom Jones will head the Texas Chapter of the American Trudeau Society for the coming year. Dr. Lawrence M. Shefts is the chapter's new vice president and Dr. John A. Wiggins, Jr., secretary-treasurer.

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